

**Our Physicians:**

Michael L. Cohen, M.D.  
Harry J. MacDannald, M.D.



**Our Locations:**

(main location)  
2121 Ygnacio Valley Rd,  
Bldg E, Ste 101  
Walnut Creek, CA 94598  
(second location)  
141 Sand Creek Rd, Ste B  
Brentwood, CA 94513

TEL: (925) 935-7667 FAX: (925) 945-7667

Website: [www.ccsleepcenter.com](http://www.ccsleepcenter.com)

Email: [info@ccsleepcenter.com](mailto:info@ccsleepcenter.com)

**PATIENT INFORMATION PACKET**

Patient Name: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Day/Date of Study: \_\_\_\_\_

Time of Arrival: \_\_\_\_\_

Location of Study: Walnut Creek ☐ Brentwood ☐

**If unable to keep this appointment please notify us AT LEAST 48 hours in advance, otherwise there is \$150 Cancellation fee. Thank you.**

**GENERAL INFORMATION**

**Prior to your study, please:**

1. Do not take any naps during the day of your study.
2. Limit caffeinated beverages within 8 hours of your study.
3. Unless otherwise instructed, take your medications as prescribed by your physician.
4. **For the Pulse Oximetry to work properly for this study, at least one finger needs to be free of nail polish and/or acrylic nails.**
5. Shower and wash your hair the day of your sleep study. Do not use hair sprays or gels. *If you have hair extensions or a hairpiece, they will need to be removed prior to your study as they can interfere with electrode placement.*
6. Bring something comfortable to sleep in and any toiletries you require.
7. Completely fill out the enclosed questionnaire(s) and give them to your technician upon arrival for your sleep study.

**Also:** \*You may bring your own pillow, a robe, and reading material, if desired. Your room will have cable TV in it.

\*Additional information is available through our website: [www.ccsleepcenter.com](http://www.ccsleepcenter.com), or our automated information system at (925) 935-7667. Normal business office hours are Monday-Friday from 9am-5pm.

**What you should expect when having your sleep study performed:**

During a diagnostic sleep study, many types of data are recorded. The Sleep Technologist will place electrodes on your skin to monitor brain waves, eye movements, certain muscle activities and heartbeat. A small sensor will be applied near your nose and mouth to monitor airflow. Respiratory effort belts will be attached around your chest and abdomen. An Oximeter sensor will be taped onto one of your fingers to measure blood oxygen saturations levels. These monitoring devices are used to ensure an accurate evaluation of your sleep. The wires will be bundled enabling freedom of movement. Your movement will not be restrained; so, for example, if you need to go to the restroom or reach for a glass of water, you will be free to do so.

During the study, the technologist will monitor your sleep and will also be available to assist you in any way should you require help. In the morning, the technologist will remove the electrodes and equipment. Later, a Sleep Technologist will review (hand-score) your study, page-by-page, and then send the results to an interpreting physician. The final report will be provided to your physician. **Results are generally ready 5-10 business days after your study is completed.**

**DIRECTIONS TO BOTH OUR WALNUT CREEK & BRENTWOOD LOCATIONS ARE INCLUDED ON THIS PAGE**

**DIRECTIONS TO OUR NEW WALNUT CREEK LOCATION**

**2121 Ygnacio Valley Rd, Bldg E, Ste 101, WALNUT CREEK, CA 94598**

We are located in Doctors Park on the corner of Walnut Ave and Ygnacio Valley Rd in Walnut Creek in Building E, Suite 101.

**Driving South on 680**

Take the North Main Street off-ramp and proceed South to Ygnacio Valley Rd. Make Left onto Ygnacio Valley Rd and proceed to **2121 Ygnacio Valley Rd which is located in Doctors Park on the corner of Walnut Ave and Ygnacio Valley Rd**. You can either make a right onto Walnut Ave and take a left in the first driveway on your left hand side. Or, go through the intersection at Walnut Ave and make a right into the driveway with a white fire hydrant off of Ygnacio Valley Rd. **We are located in Building E and Suite 101.**

**Driving North on 680**

Take Ygnacio Valley Rd off-ramp. Make right onto Ygnacio Valley Rd. Proceed to **2121 Ygnacio Valley Rd which is located in Doctors Park on the corner of Walnut Ave and Ygnacio Valley Rd**. You can either make a right onto Walnut Ave and take a left in the first driveway on your left hand side. Or, go through the intersection at Walnut Ave and make a right into the driveway with a white fire hydrant off of Ygnacio Valley Rd. **We are located in Building E and Suite 101.**

**Driving East on HWY 24**

Take Ygnacio Valley Rd off-ramp and make a Right onto Ygnacio Valley Rd. On Ygnacio Valley Rd proceed to **2121 Ygnacio Valley Rd which is located in Doctors Park on the corner of Walnut Ave and Ygnacio Valley Rd**. You can either make a right onto Walnut Ave and take a left in the first driveway on your left hand side. Or, go through the intersection at Walnut Ave and make a right into the driveway with a white fire hydrant off of Ygnacio Valley Rd. **We are located in Building E and Suite 101.**

**DIRECTIONS TO OUR BRENTWOOD LOCATION**

**141 Sand Creek Rd, Ste B, BRENTWOOD, CA 94513**

We are located Sand Creek Rd near Brentwood Blvd. Our suite is located in between businesses, "Summit Funding" and "Sunny Dental" in the Sand Creek Business Center. **There will be a red sign that reads "SLEEP" in the window in the front of the building.**

**From Pittsburg Area towards Stockton**

Take Highway 4 East towards Stockton. Continue on HWY 4 Bypass Labeled "Bypass Brentwood" (Left lanes of freeway). Continue on Highway 4 Bypass. Make a left onto Sand Creek Rd. Make a left into the Sand Creek Business Center (just before you reach Brentwood Blvd). Our suite is located in Building 141, Unit B, between "Summit Funding" and "Sunny Dental". **There will be a red sign that reads "SLEEP" in the window in the front of the building.**

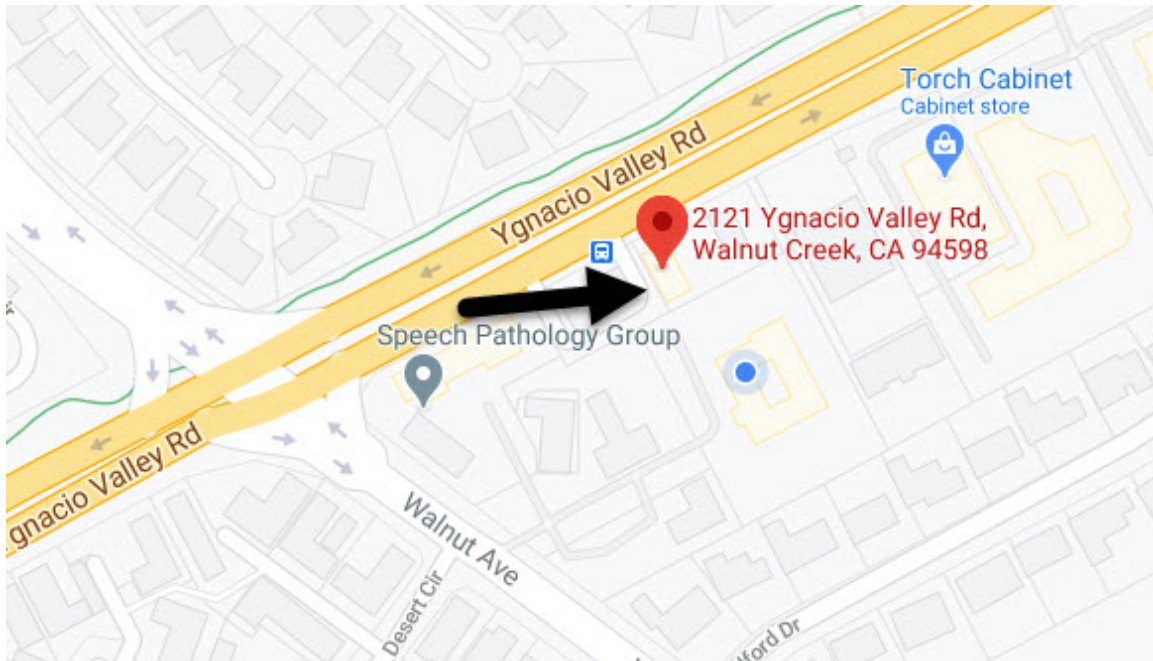
**From Stockton Area Towards Pittsburg**

Take Highway 4 West towards Pittsburg. Turn right onto Sand Creek Rd. Turn Left into the Sand Creek Business Center (just before you reach Brentwood Blvd). Our suite is located in Building 141, Unit B, between "Summit Funding" and "Sunny Dental". **There will be a red sign that reads "SLEEP" in the window in the front of the building.**

**IF YOU HAVE ANY TROUBLE FINDING EITHER LOCATION, PLEASE CALL (925) 935-7667.**

# MAP OF CONTRA SLEEP CENTER AT WALNUT CREEK

2121 Ygnacio Valley Rd, Bldg E, Ste 101, Walnut Creek CA 94598



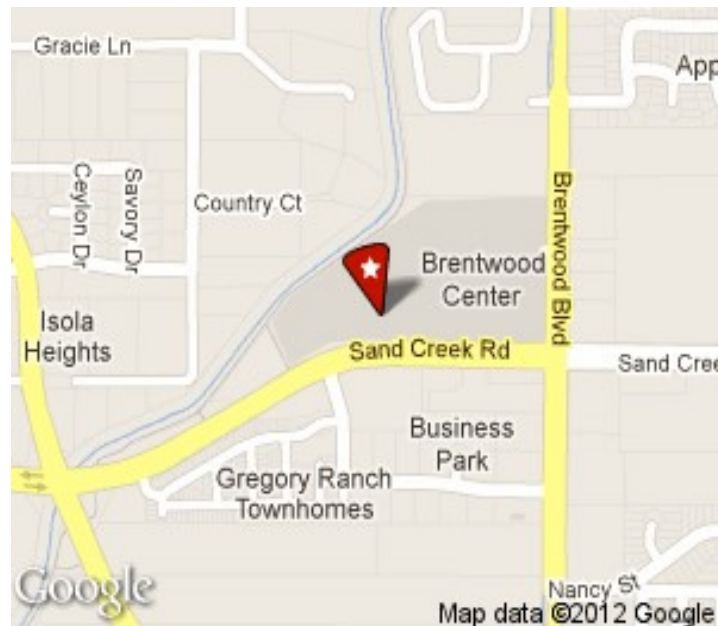
**Street view of Doctors Park 2121 Ygnacio Valley Rd, Walnut Creek CA**





# Map of Contra Costa Sleep Center at Brentwood

141 Sand Creek Rd, Ste B, Brentwood CA 94513



## Street View of 141 Sand Creek Rd, Brentwood CA



## **FREQUENTLY ASKED QUESTIONS BY OUR SLEEP CENTER PATIENTS**

### **HOW LONG WILL THE STUDY LAST?**

-Ideally, we try to capture four to eight hours of sleep to assure a sufficient amount of data for analysis by the sleep disorders physicians.

### **AM I IN A ROOM BY MYSELF?**

-You have your own private room that has a queen size bed in it. A technician will be monitoring you throughout the night in a separate control room.

### **CAN A FAMILY MEMBER/FRIEND STAY WITH ME DURING THE STUDY?**

-This is a medical procedure so it is not recommended that a family member/friend stay the entire night with you unless there are special circumstances/needs. However, you can have someone stay with you during the set-up process if that would help you feel more comfortable. The set-up takes about an hour. If the patient is a minor; a parent/guardian is welcome to stay the night with their child.

### **HOW WILL I SLEEP WITH ALL OF THE EQUIPMENT ATTACHED TO ME? WON'T IT BE UNCOMFORTABLE?**

-At first glance, you may feel appropriately attired for a film of the science fiction genre, however your freedom of movement throughout the night will be largely unrestricted. As long as you are mindful of the sensors and move with care, there is no reason why you can't sleep in the position you find most comfortable. The technologist may ask you to roll to your side or back at some point to study sleep in all positions. Most of our patients experience only a minor change in their sleep quality.

### **WILL THE TECHNOLOGIST BE ABLE TO GIVE ME MY RESULTS IN THE MORNING?**

-The technologist's job is to record the highest quality information possible and to make you feel comfortable throughout the night. The overnight part of the study is really just the tip of the iceberg. Following the study, a thorough analysis and interpretation will be made by a qualified sleep disorders center physician, along with recommendations for future steps, if indicated. The results of your sleep study will be sent to your referring physician and to you if you so desire, within 5-10 working days after your study.

### **WILL THE PHYSICIAN CONTACT ME DIRECTLY WITH THE RESULTS?**

-If you were referred to the sleep center by your physician for a sleep study your doctor will receive the interpretation of your study and should contact you with your results. It is always good to schedule a follow up appointment with your doctor a week or two after your study so you can discuss your results.

### **I GET VERY THIRSTY DURING THE NIGHT, AND AWAKEN WITH A DRY MOUTH. CAN I KEEP SOME WATER AT THE BEDSIDE?**

-Yes. We do ask that patients refrain from any caffeinated beverages during the night, however, as they interfere with sleep.

### **I WAS GIVEN A BRIEF INTRODUCTION TO CPAP PRIOR TO MY STUDY AND VIEWED AN EDUCATIONAL VIDEO ON THIS SUBJECT-DOES THIS MEAN THAT CPAP WILL BE A DEFINITE PART OF MY STUDY?**

-Patients are given an introduction prior to the study (unless the referring physician has indicated otherwise) to prepare them in the event that CPAP is indicated. The first two hours of your study help to determine if criteria for a trial of CPAP are met. If sufficient sleep is acquired, and the criteria established by the physicians for a trial of CPAP are met, a trial will be initiated.

### **WHAT IF I NEED TO GET UP TO GO TO THE WASHROOM?**

-The technologist recording your sleep study will be in the lab area throughout the night. A camera will monitor you and your voice will be audible via intercom system for the duration of your study. Simply call the technologist, who will assist you in getting up and walking to the washroom. If you prefer not to walk to the washroom, urinals are always available. Let us know if you prefer a commode.

### **I WILL BE LEAVING FOR WORK FROM THE SLEEP CENTER IN THE MORNING FOLLOWING THE STUDY. WILL I BE ABLE TO GET TO WORK ON TIME?**

-Inform your technologist of any scheduling concerns before your study begins, and every attempt will be made to perform a complete study within those boundaries. Incidentally, bathing facilities are not located in the facility.

### **I USUALLY TAKE MEDICATION JUST BEFORE BEDTIME-SHOULD I AVOID TAKING IT ON THE NIGHT OF MY STUDY?**

-Unless your physician has specifically instructed you otherwise, you should continue to take your normal medications before bedtime. In performing the study, we try to adhere to your normal routine as closely as we can within lab protocols. Please do list your medications on the pre-sleep questionnaire that the technologist gives you.

**If you have any unanswered questions/concerns, our staff and chief technologist are available between 9:00am-5:00pm, Monday through Friday at (925) 935-7667 to assist you.**

## **WHAT IS SLEEP APNEA?**

Sleep Apnea is a disorder that causes people to frequently stop breathing while sleeping. People who suffer from sleep apnea stop breathing many times during their sleep. As a result, they fail to get oxygen their body needs and a restful night's sleep.

### ***IS SLEEP APNEA A SERIOUS DISORDER?***

Yes. If left untreated, sleep apnea increases your risk for heart problems and stroke. It can also lead to:

- ☐ Excessive daytime sleepiness
- ☐ Decreased performance at work
- ☐ Increased possibility of accidents while driving or operating heavy equipment
- ☐ Lack of concentration
- ☐ Impaired sexual function
- ☐ Memory loss

### ***WHAT CAUSES SLEEP APNEA?***

Obstructive Sleep Apnea (OSA) is the most common form of the disorder. It is caused by structures in the throat blocking the flow of air in and out of the lungs during sleep.

Central Sleep Apnea (CSA) results from the brain not signaling you to breathe during sleep. In a sense, the brain "forgets" to breathe during sleep.

Mixed Sleep Apnea (MSA) is a combination of both OSA and CSA.

Many people who have sleep apnea don't even know they have it. Often a family member or bed partner will notice the signs of sleep apnea before you do.

### ***WHAT ARE THE SYMPTOMS OF SLEEP APNEA?***

- ☐ Restless Sleep
- ☐ Morning Headaches
- ☐ Loss of Energy
- ☐ Irritability, short temper
- ☐ Anxiety or depression
- ☐ Falling asleep during the day at work, while watching TV, listening to lectures, reading
- ☐ Loud snoring interrupted by silence and then gasps
- ☐ Forgetfulness
- ☐ Falling asleep while driving
- ☐ Difficulty concentrating
- ☐ Mood or behavior changes
- ☐ Decreased interest in sex

### ***A SLEEP STUDY CAN TELL YOU WHETHER YOU HAVE SLEEP APNEA.***

Talk to your doctor. If he or she suspects you have sleep apnea, you will be asked to have a sleep test to confirm this diagnosis. During a sleep test, you will be observed as you sleep. Specially trained technologists will record many kinds of data about your sleep and breathing problems. As a result of testing, you will find out whether or not you have sleep apnea. Testing can also tell what type of sleep apnea you have, and what kind of treatment will help you most.

### ***WHAT CAN BE DONE ABOUT SLEEP APNEA?***

Sleep apnea is a correctable health problem. Not long ago, surgery was thought to be the best way to treat sleep apnea. In some cases surgery may still be necessary, but most patients can be treated successfully through other means of therapy.

One therapy relies on Continuous Positive Airway Pressure (CPAP)- which is the most prescribed treatment for sleep apnea. CPAP is delivered through a small amount of pressure, applied through a mask over the nose. This pressure prevents structures in your throat from blocking the air movement in and out of the lungs while you sleep. You will experience almost immediate relief from your symptoms by using CPAP therapy.

Discuss treatment options with your physician. With proper treatment, sleep apnea sufferers can lead normal lives.

### ***YOUR PHYSICIAN MAY ALSO SUGGEST THAT YOU:***

- ☐ Lose weight
- ☐ Avoid alcohol, especially close to bedtime
- ☐ Take medications with caution, especially sleeping pills; some can depress breathing and can make sleep apnea worse.

CONTRA COSTA SLEEP CENTER (CCSC)  
2121 Ygnacio Valley Rd, Bldg E Ste 101, Walnut Creek, CA 94598  
141 Sand Creek Rd, Ste B, Brentwood, CA 94513  
Phone (925) 935-7667 Fax: (925) 945-7667  
[www.ccsleepcenter.com](http://www.ccsleepcenter.com)

**Patient Name:** \_\_\_\_\_  
(please print clearly)

**PATIENT AUTHORIZATION FOR SERVICES PROVIDED & PAYMENT AGREEMENT**

*I hereby authorize Contra Costa Sleep Center to release any and all of my medical records to my referring physician, as well as any other physicians involved in my care.*

**Please list if there are any physicians that you DO NOT wish us to release your medical records to:**

\_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

***Insurance Coverage:***

Most insurance companies and other third-party payers of healthcare benefits will pay in whole or in part for the services and products ordered by your physician and provided by CCSC.

CCSC will contact your insurer to verify your coverage and obtain authorization to provide services to you and bill your insurance payer in the amounts they approve for payment. We will provide you with our findings upon your inquiry; however, CCSC is not responsible for the completeness and accuracy of your payer's information. We therefore strongly recommend that you also contact your insurer so that you have a complete understanding of the benefits your plan affords you.

Please further understand that the authorization we obtain is only valid through its date of expiration and provided that nothing in your benefits has changed, such as your policy being canceled or expired, pre-existing condition determination, or change in employer or primary care physician.

***Patient Payment:***

CCSC will bill your health benefits payer as a courtesy. Payment for services, equipment, products or supplies provided to you are your sole and exclusive responsibility. This amount may include any and all amounts denied or not reimbursed by your insurer, a co-pay or deductible as required by your benefits provider. Payment is due in full, paid to CCSC, no later than 30 days from the date on the CCSC statement sent to you.

Additionally, should your insurer pay you directly for the services provided by CCSC, you agree to reimburse CCSC in the same amount within 15 days from the date on the payment check, as well as any personally owed amounts in 30 days as noted above.

By signing below, I agree that I have read and understand the above, and also agree to personally pay directly to CCSC any and all amounts not paid for any reason by my insurer within 30 days of the date on the CCSC statement. I also authorize CCSC to release any information necessary to my health benefits payer to process my insurance claim(s).

**Responsible Party (if other than patient):** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## **Contra Costa Sleep Center**

### **PATIENT RIGHTS AND RESPONSIBILITIES**

***All patients shall have rights, which include, but are not limited to the following:***

- ☐ To be given a statement of services available by the agency and related charges.
- ☐ To have access to the services, regardless of race, religion, sex or source of payment.
- ☐ To have the right to request and receive an itemized and detailed explanation of the total bill for services rendered and products supplied.
- ☐ To have access to the physician directing his/her care and information regarding his/her diagnosis, treatment or prognosis.
- ☐ To be communicated to in a way that he/she can reasonably expect to understand.
- ☐ To be informed about the nature of any technical procedure that will be performed, as well as who will perform the procedure.
- ☐ To have the right to refuse treatment (as permitted by law) and be informed of the medical consequences of such refusal.
- ☐ To seek assistance in finding and transferring the provision of services to another agency.
- ☐ To receive care in a timely manner, appropriate to his/her needs.
- ☐ To be treated with consideration, respect and full recognition of his/her dignity, individuality, and privacy. To be assured of confidentiality in treatment and records of such and be allowed to approve or refuse their release to any outside agencies.
- ☐ To have competent and qualified personnel carry out the services for which they are responsible.
- ☐ To be provided access to the State Health Department for problems about services.
- ☐ To voice grievances and recommend changes in policies and services. The patient will be informed of Contra Costa Sleep Centers' mechanism of receiving and resolving patient complaints.
- ☐ To be allowed to have patients' family or guardian exercise the patients' rights when the patient has been judged incompetent.

***All patients shall have responsibilities, which include, but are not limited to the following:***

- ☐ To provide, to the best of his/her knowledge accurate and complete information about present medications and/or other matters relating to his/her healthcare.
- ☐ To report unexpected changes in his/her condition to those clinicians responsible for the management of his/her care.
- ☐ To make it known whether he/she clearly understands a contemplated course of action and what is expected of him/her.
- ☐ To follow the treatment plan recommended for his/her care by the primary care physician and other allied health professionals, including nurses, pharmacists, and dieticians.
- ☐ To keep appointments and, when unable to do so for any reason, to notify Contra Costa Sleep Center **NO LATER THAN 48 HOURS** prior to the scheduled appointment; **otherwise there will be \$150 Cancellation fee.**
- ☐ To assume responsibility for his/her actions if he/she refuses treatment or does not follow the instructions as set forth by his/her primary care physician and the professional staff of Contra Costa Sleep Center.
- ☐ To assure that the financial obligations of his/her health care are fulfilled as promptly as possible.
- ☐ To be considerate of the rights of Contra Costa Sleep Center personnel and representatives.
- ☐ To be respectful of the property of Contra Costa Sleep Center and its personnel.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_



<b>CONTRA COSTA SLEEP CENTER GENERAL HEALTH QUESTIONNAIRE</b>
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**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(please print clearly)

**Date of Birth:** \_\_\_\_\_

**Please answer the following questions regarding your general health.  
Please *circle* the appropriate answer.**

Do you have high blood pressure?	Yes	No
Have you experienced a heart attack?	Yes	No
Do you have a history of irregular heartbeats?	Yes	No
Have you experienced chest pain?	Yes	No
Have you had prior heart surgery?	Yes	No
Do you have a pacemaker?	Yes	No

**Do you have a history of the following disorders?**

Asthma	Yes	No
Bronchitis	Yes	No
Chronic Obstructive Pulmonary Disease (COPD)	Yes	No
Emphysema	Yes	No
Tuberculosis Exposure	Yes	No
Diabetes	Yes	No
Stroke	Yes	No
Congestive Heart Failure	Yes	No
Hepatitis (List type: _____)	Yes	No

**Please list any other medical history/conditions below:**

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<b><u>Are you having this sleep study post surgery?</u></b>	<b>Yes</b>	<b>No</b>
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**If yes, when did you have surgery** \_\_\_\_\_

**What type of surgery** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Contra Costa Sleep Center**  
**Medications QUESTIONNAIRE-continued**

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

**Please list all prescribed medications that you take on a daily basis:**

[illegible]

**CONTRA COSTA SLEEP CENTER****INSTRUCTIONS**

1. Please print clearly and complete all information
2. Please furnish a copy of your insurance card (front & back)

**PATIENT TO COMPLETE**

LAST NAME	FIRST NAME	MIDDLE INITIAL
ADDRESS (NUMBER, STREET)	CITY	STATE ZIP CODE
HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER	DATE OF BIRTH(MM/DD/YY)
SEX: MALE FEMALE	SOCIAL SECURITY NUMBER	MARITAL STATUS M S W D DP
EMPLOYER	OCCUPATION	
EMPLOYER ADDRESS	EMPLOYER PHONE NUMBER	
EMAIL ADDRESS		

**EMERGENCY/REFERRAL INFORMATION**

PRIMARY CARE PHYSICIAN	PCP PHONE NUMBER	PCP ADDRESS
REFERRING PHYSICIAN (IF DIFF THAN PCP)	REFERRING PHYSICIAN PHONE #	REFERRING PHYSICIAN ADDRESS
FAMILY MEMBER OR FRIEND	HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER
RELATIONSHIP TO PATIENT	ADDRESS	

**ELIGIBILITY GUARANTEE SECTION**

PRIMARY INSURANCE NAME	POLICY NUMBER	GROUP NUMBER
PRIMARY INSURANCE PHONE #	PRIMARY INSURANCE ADDRESS	
SUBSCRIBER (IF OTHER THAN PATIENT)	RELATIONSHIP TO PATIENT	
SUBSCRIBER DATE OF BIRTH	SUBSCRIBER SOCIAL SECURITY NUMBER	
SECONDARY INSURANCE NAME	POLICY NUMBER	GROUP NUMBER
SECONDARY INSURANCE PHONE #	SECONDARY INSURANCE ADDRESS	
SUBSCRIBER (IF OTHER THAN PATIENT)	RELATIONSHIP TO PATIENT	
SUBSCRIBER DATE OF BIRTH	SUBSCRIBER SOCIAL SECURITY NUMBER	

I hereby authorize Contra Costa Sleep Center to contact my insurance company to verify my insurance coverage. I understand that if I am not eligible, I am liable for all charges rendered. I agree that if this information is not true, I (or the above person named financially responsible for me) will pay in full all such charges. I also authorize Contra Costa Sleep Center to release any medical information necessary to process my insurance claim. I hereby authorize payment of medical benefits directly to: CONTRA COSTA SLEEP CENTER.

1455 Montego, Ste 102, Walnut Creek, CA 94598 Phone (925) 935-7667 Fax (925) 945-7667

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**SIGNATURE OF PATIENT**


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**SIGNATURE OF INSURED**


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**DATE SIGNED**

# CONTRA COSTA SLEEP CENTER

## QUESTIONNAIRE FORM

Patient's Name \_\_\_\_\_ Date: \_\_\_\_\_

M or F \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_ Phone # \_\_\_\_\_

D.O.B. \_\_\_\_\_ Age \_\_\_\_\_ Physician \_\_\_\_\_

\*\*\*Please answer the following questions regarding your normal sleep patterns\*\*\*

	(Please Circle)	
	Yes	No
Do you snore at night?		
If yes, how would you rate severity?      Mild      Moderate      Severe		
Do you have difficulty falling asleep at the beginning of the night?		
Do you have difficulty staying asleep throughout the night?		
If yes, how many times do you wake up during the night? _____		
How long does it take you to fall back to sleep? _____		
Have you been told that you have pauses in your breathing while asleep?		
Do you experience excessive daytime tiredness?		
Do you experience a restless sensation in your legs while lying in bed?		
If yes, how frequently: Occasionally _____ About 50% of the time _____ Almost every night _____		
Have you been told that you make kicking and twitching movements while asleep?		
Do you occasionally awaken feeling paralyzed?		
Do you feel sudden loss of strength in your legs or arms during the day?		
If yes, are these brought on by a sudden frightening event or laughter? _____		

\*\*\*Circle the statement(s) that apply to you\*\*\*

Do you frequently wake up with:      a dry mouth      headaches      excessive sweating      choking and/or gasping

nasal congestion      chest pain      heart burn

How likely are you to fall asleep during the day in the following situations, in contrast to just feeling tired?  
 0 = would never doze / 1= slight chance / 2 = moderate chance / 3 = high chance

### Situation

Sitting and reading  
 Watching TV  
 Sitting inactive in a public place (i.e. movie theater)  
 As a passenger in a car for an hour without a break  
 Lying down to rest during the day when circumstances permit  
 Sitting and talking to someone  
 While in a car that is stopped

### Chance of falling asleep

0	1	2	3
0	1	2	3
0	1	2	3
0	1	2	3
0	1	2	3
0	1	2	3
0	1	2	3

(0 = No Chance; 3 = High Chance)

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

CONTRA COSTA SLEEP CENTER

PRE-STUDY QUESTIONNAIRE FORM (Please fill out these questions on the day of your scheduled study)

NAME: \_\_\_\_\_ STUDY DATE: \_\_\_\_\_

1. What time did you go to sleep last night? \_\_\_\_\_:\_\_\_\_\_AM/PM
2. Compared to usual, did you go to sleep last night: (Circle One) EARLIER SAME LATER
3. What time did you wake this morning? \_\_\_\_\_:\_\_\_\_\_AM/PM
4. Compared to usual, did you wake this morning: (Circle One) EARLIER SAME LATER
5. How many hours sleep did you get for the last two nights: LAST NIGHT \_\_\_\_\_Hours  
NIGHT BEFORE LAST \_\_\_\_\_Hours
6. Did you get enough sleep last night? Yes No
7. Have you had any alcoholic or caffeinated beverages today or tonight? Yes No  
If so, WHAT? \_\_\_\_\_ WHEN? \_\_\_\_\_
8. Do you usually have alcoholic or caffeinated beverages? Yes No
9. Did you take any naps today or tonight? Yes No  
If so, WHEN? \_\_\_\_\_
10. Do you usually take naps? Yes No
11. Have you felt ill today or tonight? Yes No
12. Do you usually sleep alone? Yes No

ANSWER ALL QUESTIONS BELOW BY CIRCLING THE NUMBER FO THE BEST RESPONSE

1 = NOT AT ALL

2 = SOMEWHAT

3 = VERY

- |  |   |   |   |
|--|---|---|---|
| 13. How physically tired do you feel right now?    | 1 | 2 | 3 |
| 14. How mentally tired do you feel right now?      | 1 | 2 | 3 |
| 15. How tense or anxious do you feel right now?    | 1 | 2 | 3 |
| 16. How depressed or "blue" do you feel right now? | 1 | 2 | 3 |
| 17. How sleepy do you feel right now?              | 1 | 2 | 3 |

Phone (925) 935-7667 \*\*\* Fax (925) 945-7667